UTAH VALLEY
REGIONAL MEDICAL CENTER

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MEDICAL BULLETIN

SURGEON ADDRESSES CONFERENCE IN INDIA

Klint H. Stander, M.D., F.A.C.S.

In February 1985, Dr. Klint H. Stander presented a paper at the World Congress for Open Heart Surgery in Bombay, India. The paper was entitled "TREATMENT OF ACUTE MYOCARDIAL INFARCTION WITH STREPTOKINASE INFUSION FOLLOWED BY CORONARY ARTERY BYPASS GRAFT SURGERY". The study was done in conjunction with Dr. John Frischknecht, Dr. Charles Dahl and Dr. Glade Smith at UVRMC, Provo, Utah and Dr. J. Ralph Macfarlane and Associates at McKay Dee Hospital in Ogden, Utah.

It has been shown that the majority of myocardial infarctions are caused by a small blood clot at a site of a narrowing of the coronary artery by cholesterol plaque. It has further been shown that large numbers of these small blood clots can be dissolved by streptokinase. This study reported the results of surgery for coronary artery bypass grafts on 57 patients who had acute myocardial infarctions treated with streptokinase therapy. The study covered the period of time from September 1982 through December 1984. During that time there were 781 patients with acute myocardial infarctions seen at our institutions. Of these, 122 had streptokinase therapy for lysis of clots in totally occluded coronary arteries.

Of the 57 patients operated on there was one surgical mortality, a rate of 1.9% which is significantly less than the operative mortality for coronary artery bypass grafts on patients with acute myocardial infarction who have not had streptokinase treatment.

Other important findings in the study were that patients were seen to markedly improve their cardiac function as indicated by left ventricular ejection fractions while being followed on Heparin after the streptokinase treatment of occluded coronary arteries. We have found that, if necessary, surgery can be perfomed safely on the same day streptokinase is given. Postoperative hemorrhage was controlled well in most cases by the administration of fresh frozen plasma and postoperative blood usage in these patients was only slightly increased from that of elective coronary artery bypass graft surgery patients.

Strong recommendations were given to increase the use of streptokinase therapy for acute myocardial infarctions. One important aspect of this has been to give intravenous streptokinase as soon as the diagnosis can be made by history and ECG findings. This has been done safely and with success in the emergency room of this and referring hospitals. Cardiac catheterization should then be done on an

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INSIDE MEDICAL BULLETIN

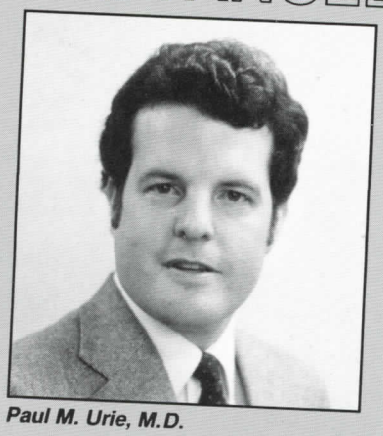
SURGEON ADRESSES CONFERENCE IN INDIA *continued*

emergency basis as soon as possible. Intracoronary streptokinase infusion is then done along with complete coronary and left ventricular angiography. The patients who have successful lysis of the intracoronary thrombosis can be divided on long-term anticoagulation. The second group are those who have a residual lesion in a single coronary artery. In these balloon dilitation is done immediately. The third group are those with residual lesions in multiple coronary arteries. In these, coronary artery bypass graft surgery is recommended. The fourth group are those with multiple residual lesions in the coronary arteries and poor left ventricular ejection fractions. They are placed on Heparin therapy and the left ventricular ejection fraction is followed by echocardiogram. When it improves, the patients undergo surgery for coronary bypass grafts.

Final conclusions of the paper are 1) Streptokinase intravenous, intracoronary or combined decreases the mortality risk of coronary bypass graft surgery in acute myocardial infarctions significantly. 2) A large number of acute myocardial infarction patients will benefit greatly from combined streptokinase therapy followed by balloon dilitation of coronary artery lesions or coronary artery bypass graft surgery. 3) Clinical application of intravenous streptokinase as soon as the diagnosis of acute myocardial infarction is made increases the incidence of opening the thrombosed coronary artery. 4) Average blood usage for coronary artery bypass graft surgery in patients who have had streptokinase therapy is not significantly higher than for elective coronary artery bypass grafts. 5) Lysis of the clot occluding the coronary artery in a patient with an acute myocardial infarction reduces the necessity for emergency surgery in many cases and prevents loss of heart muscle in a large number of patients. Surgery can then be carried out as soon as the patient stabilizes and streptokinase effect decreases. 6) Ejection fraction of the left ventricle will frequently improve significantly after the occluded coronary artery is opened with streptokinase.

Coronary artery disease is a significant world-wide problem. The incidence is high in the United States, Europe and Australia. It is of interest to note that it is very uncommon in India, China and most African nations. All of the factors responsible for these differences are not understood. Heredity, diet, tobacco, and physical activity are felt to be important factors but they do not explain the whole situation.

LAB SPEEDS MEDICAL TREATMENT WITH ADVANCED TELECOMMUNICATIONS



Paul M. Urie, M.D.

A patient is admitted to a small southern Utah hospital with an undiagnosed illness. His test samples are sent to the laboratory at Utah Valley Regional Medical Center for analysis, and three days later his physician has the results he needs to begin treatment. At least that's how it used to be. But now, with a fully-computerized laboratory and regional telecommunications system, UVRMC provides lab test results to nine satellite hospitals and clinics within 24 hours.

Another five to ten facilities are expected to join the network soon, giving UVRMC the most sophisticated laboratory service of any hospital its size. "Only larger commercial labs like Smith-Kline have systems like it," says Paul M. Urie, M.D., Ph.D., staff pathologist and computer systems specialist.

Results of routine lab tests used to take three days (difficult diagnoses even longer) because the sample and the report both traveled by mail. A courier service now brings most of the work to the medical center at the end of each day for the evening technologists to analyze. The reports are then transmitted over telephone lines and printed out at the satellite facility the next morning.

The equipment that analyzes the bulk of samples is interfaced directly with the communication lines, eliminating human error in both reading and writing down results. Still, the technologist verifies each report and continually runs checks on the equipment to ensure its accuracy.

"The bottom line for the patient is better quality of care," says Tom Helton, assistant lab manager. "A faster, more accurate test result means a faster diagnosis and, therefore, better medical treatment. It also means a shorter hospital stay, which really helps cut costs."

Physicians and staff at the smaller hospitals can also call for consultations with pathologists and other lab personnel at UVRMC on a designated toll-free line. "We're doing all we can to bring the most up-to-date information to all the health care facilities we serve," says Helton. "We really are a regional medical center and a regional laboratory."

UVRMC's laboratory processes over one million specimens each year, or about 1200 tests every working hour. Before computerization, every test was recorded on a form and filed separately in the appropriate sub-area of the lab. Now all tests are stored in the computer bank under the patient's name and interfaced with all his other hospital records.

"This is a great help to the physician," explains Dr. Urie. "Previously, he would have to call each lab department for the different tests on his patient. Now, he can immediately bring up a complete laboratory history at the time of admission."

The computer can store information for 400,000 patients, which is about four years worth of space. After that, the files are backlogged onto micofiche.

SKI RACER DIES DESPITE HEROIC EFFORT

UVRMC Medical Team works to save injured skier. Ski resort personnel look on.

The scene was a beautiful spring morning at Grand Targhee ski resort near Jackson, Wyoming. A group of doctors and nurses from Utah Valley Regional Medical Center was there for the great spring skiing. They arose early on Saturday, April 18, filled with anticipation for the day ahead on the slopes. The group included Dr. James Clayton, plastic surgeon, Dr. Charles Dahl, cardiologist; ER nurses Kay Goodson, Sherise Gregerson, Carlie Ellis and Jean Lundquist; and ICU nurses Cindy Hall and Mary Saldutte.

While the hospital group was not there to compete, it so happened that the Third Annual Ironman Decathlon was underway and excitement was in the air as the downhill competition got underway.

Disaster struck almost immediately as an Ironman contender, Dean Kevin Griffin, from Jackson Hole lost control and skidded off the icy ski trail into a grove of trees. His estimated speed was in excess of 60 mph on the extremely fast course. The impact left him with critical injuries and numerous fractures.

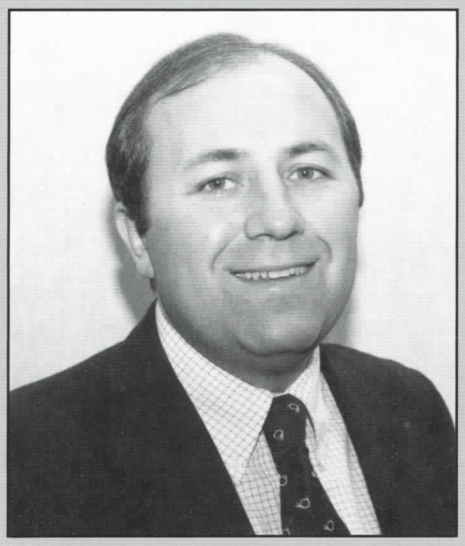
He was transported by toboggan to Grand Targhee's First Aid Station outside the base lodge by patrolmen who administered CPR in-route as best they could. When they arrived, Griffin had no pulse and heartbeat. He was in full cardiac arrest.

Alerted to the situation, and to everyone's amazement and relief, the UVRMC medical team descended on the scene and took over the rescue effort. A surgeon and a cardiologist, four emergency room nurses and two intensive care nurses, all worked with practiced efficiency. It's improbable that an injured skier, anywhere, ever had better, more expert on-site care.

With drugs and a great deal of skill, the team soon had the injured skier's heart beating and he was stabilized for transport by the time the Life-Flight helecopter arrived from Pocatello. The racer still had a strong pulse when he arrived at Riverview Hospital in Idaho Falls—but was found to have a severe spinal fracture and died while the surgical team was working on him. Injuries in addition to a fractured neck included head damage, two broken femurs and internal bleeding.

Despite the tragic outcome, the heroic effort on the part of our doctors and nurses was extraordinary and greatly appreciated by the ski resort people and local authorities. A ski resort official expressed astonishment at the rapid, expert care that the racer received and noted that he would have had no chance at all without this gallant effort.

UVRMC ADDS PODIATRY DEPARTMENT TO MEDICAL STAFF



Mark Rogers, D.P.M.
Chairman, Podiatry Department

The medical staff director and governing board of Utah Valley Regonal Medical Center have given full admitting privileges to six Utah County podiatrists and approved Mark Rogers, D.P.M. as chairman of the new department.

According to Mark J. Howard, UVRMC administrator, the move reflects a consumer-oriented, progressive approach to medical care. "Medical doctors, osteopaths, dentists, and podiatrists are all recognized medical practitioners by the government and major health insurers. With the creation of a podiatry department, we also have them all on our medical staff."

Podiatrists, says Dr. Rogers, "treat anything having to do with the foot. Our emphasis is not only on relieving pain, but also keeping the foot functioning properly." Some specific areas of podiatric medicine include congenital abnomalities, gait irregularities, and developmental problems in children; athletic and other traumatic injuries; and degenerative effects of diabetes, arthritis, and gout in the elderly.

Members of the newly-created podiatry department are doctors Allan Gomez, Gary Morley, Gary Ridge, Mark Rogers, Tom Rogers, and McKay Winkel.

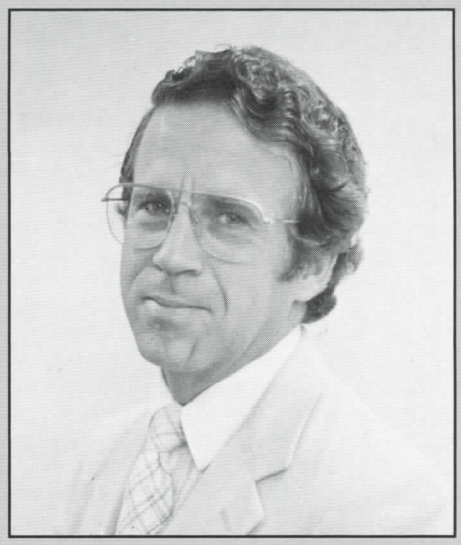
KIRKPATRICK ELECTED PRESIDENT OF NEUROSURGICAL SOCIETY

Douglas B. Kirkpatrick, M.D., neurosurgeon, has been elected president of the Utah State Neurosurgical Society. Objectives of the state society are to ensure the quality of neurosurgical practice in Utah and keep abreast of current trends and developments through the national society.

Dr. Kirkpatrick has been a partner in the Utah Neurological Clinic and a member of UVRMC's medical staff since 1977. He graduated from the Duke University School of Medicine and completed his surgical internship at the University of California at Los Angeles. After a year of surgical residency at UCLA, he undertook a year's research in neurophysiology at the Brain Research Institute. He then completed his neurosurgery residency and moved to Utah to practice.

Dr. Kirkpatrick is certified by the American Board of Neurological Surgeons and is a Fellow of the American College of Surgeons, the Congress of Neurological Surgeons, and the Rocky Mountain Neurosurgical Society.

He is married to the former Terrie Heinz, and they live with their five children in Mapleton.



Douglas B. Kirkpatrick, M.D.

COUGAR HUNTING WITH A CAMERA

As told to Jerry Sorensen by Dr. Howard Francis.

When most people think of a hobby, it usually has to do with collectibles or tinkering or something fairly routine. Not so with Dr. Howard Francis, a Provo OB-GYN specialist, who makes a hobby out of hunting cougars with a camera.

A typical hunt begins at 4 a.m. with two good friends, a pack of Black and Tan hounds and a trusty mule. "A horse will do," according to Dr. Francis, "and some people prefer them, but I like mules."

Mules, he says, are more sure footed in the mountains, less skittish, more sensible and they can go all day through the roughest terrain without getting tired. They're also better in snow and that can be a big factor when it's "belly-deep."

The hounds are **not** optional, says Dr. Francis. In fact, they are indispensable when it comes to tracking and treeing a cougar. Hunters and campers can be out in the woods for years and never see a cougar. But they are there just the same according to Dr. Francis. They're just too stealthy and wise to be seen, and they go out of their way to avoid contact with man.

The hunt, even with a camera, requires a "pursuit" permit from the Forest Service. A handful of "kill" permits are issued each year, as well, though Dr. Francis and his friends, Daryl Tyler and George Rasband, shoot only with a camera. "It's the thrill of the chase that makes it worthwhile," said Dr. Francis, "though we did tree a huge old male once that would have made the Boon and Crockett trophy book. He must have weighed at least 185 pounds and that's one time we wished we had had a kill permit." Such large old males actually eat their young, said Francis, and the Forest Service encourages a certain number of such kills to keep them from destroying their young.

Spanish Fork Canyon is one of Francis' favorite hunting grounds, and the chase begins once the hunters come across some reasonably fresh cougar tracks. At this point, the "strike" or lead hound is released to follow the tracks. This hound is trained and experienced and can determine in a short time if the tracks are fresh enough to lead the hunters to the cougar.

If the tracks do prove fresh, the other hounds are released and the pack of hounds romp joyfully through the woods, howling after the cougar's scent. The hunters are hard pressed to keep up and tend to follow the progress of the hounds by the sound of their strident voices rather than by sight. When the tempo of the howling reaches a hysterical pitch, they know the hounds have treed the cougar. The dogs become so frenzied in their scramble to reach the cougar that sometimes they are actually able to climb the tree and there is a furious skirmish as the cougar hisses and swats at the dogs to keep them at bay.

When the hunters arrive, the dogs are called off and chained up to keep them from the cougar. Picture taking commences and Dr. Francis and the other hunters climb into the tree to get closeups. As dangerous or downright crazy as this sounds, Dr. Francis says the cougar will not attack. "They are basically shy and very scared and only want to run away," he casually explains.

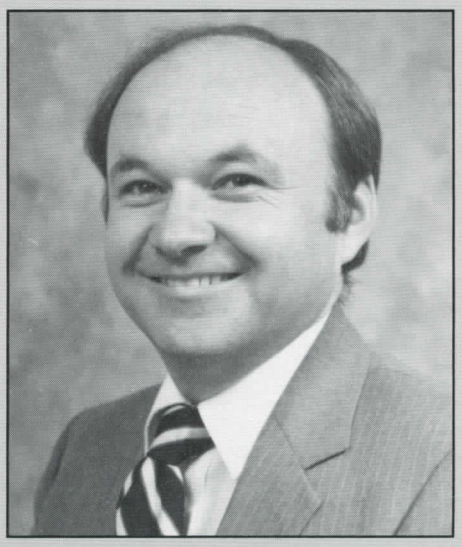
After the picture taking is complete, the cougar is allowed to escape from the tree and the young, inexperienced pup-hounds get a chance to pursue the cat for a time to gain experience. "This is how hounds are trained to track cougars," said Dr. Francis. "They really enjoy it and they never hurt the cougar. We have great respect and admiration for these beautiful animals," said Dr. Francis, "and we feel it a privilege to be able to hunt them and see them up close without hurting them."

THERAPEUTIC UPDATE

by Bruce H. Woolley, Pharm.D.

INTRODUCTION

The latter part of 1984 and early 1985 have seen an increase in clinical trial and release of new drug entities. Although many of these new agents don't seem to be significant enough to affect total prescription activities, some may significantly alter prescribing patterns. In each issue we will review one or two new agents from the outline that follows.



Bruce H. Woolley, Pharm.D., Director, University Health Services Professor, Applied Pharmacology and Therapeutics, Brigham Young University.

ANTI-INFECTIVES

Cephalosporins

CEFUROXIM (Zinacef/Glaxo)
CEFTIZOXIME (Cefizox/SKF)
CEFOPERAZONE (Cefobid/Pfizer)
CEFONICID (Monicid/SKF)
CEFORANIDE (Precef/Bristol)

Beta-lactamase Inhibitor

CLAVULANIC ACID (Beecham)
Naturally occurring beta-lactam product with little intrinsic antibiotic activity. In small doses, irreversibily inhibits beta-lactamase and acts synergistically with penicillins and cephalosporins.

Erythromycin

RU 965 (Hoechst-Roussel)
A modified form of erythromycin base currently in clinical trials. Has a unique pharmacokinetic profile which, with long half-life (will have once a day dosage), and appears to have significantly lower GI upset.

Antivirals

ACYCLOVIR (Zovirax/BW)
SOMANTADINE (Pennwalt)
In clinical trials and appears to be somewhat effective in herpes.
HEPTAVAX B (genetically engineered/MSD)
In clinical trials at the present time. Will resolve concern that the currently available human plasma derivative might transmit acquired immune deficiency syndrome (AIDS). Synthesized from yeast modified to carry a gene encoding a hepatitis B surface antigen.
INTERFERON ALPHA 2

Antifungals

CICLOPIROX (Loprox/Hoechst)
ECONAZOLE (Spectazole/Ortho)

Clinical Trial

IMIPENEM (Primaxin/MSD)
AZTREONAM (Azactam/Squibb)

TRANQUILIZERS/SEDATIVES

BUSPIRONE (Buspar/Mead Johnson)

Benzodiazepines

CLOBAZAM (Frisium/Hoechst)
Structurally and pharmacologically related to available agents of this class. A weak hypnotic agent. Anticonvulsant action similar to diazepam.
NITRAZAPAM (Mogadon/Roche)
Used widely for many years in Europe and Canada as a sedative/hypnotic. Frequency of adverse effects increases with age and dosage.
QUAZEPAM (Schering)
Similar to other benzodiazepines. Being investigated for use as a sedative/hypnotic.

Neuroleptics

PIMOZIDE (Orap/McNeil)
Antipsychotic agent for the management of chronic schizophrenia and related disorders. It is an analog of butyrophenone and a derivative of the meperidine-like analgesics.

Antidepressants

NOMIFENSINE (Merital/Hoechst)
Tetrahydroisoquinioline derivative effective against endogenous and reactive depression. Unique as it markedly inhibits dopamine reuptake.
BUPROPION (Wellbutrin/Burroughs Wellcome)
Structurally similar to amphetamine. Does not effect classic antidepressant pathways.
ZIMELIDINE (Zelmid/Merck)
Related to pheniramine with active major metabolite. Does not appear to potentiate CNS effects of alcohol. Different interaction profile.

Nootropic Agents (improve memory) (Alzheimer's)

ERGOLOID MESYLATES (Hydergine/Sandoz)
PIRACETAM (Lederle)
ANIRACETAM (Roche)
PRAMIRACETAM (Warner-Lambert)

CIRCULATORIES/DIURETICS

Diuretics

(MAXIZIDE/MYLAN)
Approved by the FDA in October, 1984 as a diuretic antihypertensive product to complete with Smith Kline Beckman Corp.'s Dyazide.

UPDATE *Continued*

Beta Blockers

LABETALOL (Normodyne/Schering) (Tradate/Glaxo)
Dual alpha and beta adrenoceptor blocker for the management of hypertension.

Angiotesin Converting Enzyme Inhibitors (ACE)

ENALAPRIL (Vasotec/MSD)
A prodrug that is metabolized to an ACE Inhibitor. 10 to 20 times more potent than captopril. Lacks dermatoligic, renal, hemtologic and taste effects of captopril. Does have postural hypotension problems.

Antihypertensives

GUANADREL (Hylorel/Penwalt)
GUANABENZ (Wytensin/Wyeth)
INDAPAMIDE (Lozol/USV)

Calcium Channel Blockers

Nifedipine (Procardia/Pfizer)
VERAPAMIL (Calan/Searle)
(Isoptin/Knoll)
DILTIAZEM (Cardizem/Marion)
FLUNARIZINE
Selective calcium channel blocker used clinically in Europe. Expected to be the drug of choice to preserve the brain following cardiac arrest.

Hemorheologics

PENTOXIFYLLINE (Trental/Hoechst)
Approved by FDA in September, 1984 and available in October. Improves blood flow through plaque-lined arteries of the arms and legs.

Antiarrhythmics

AMIODARONE (Cordarone/Ives)
Therapy of life-threatening supraventricular and ventricular arrhythmias in patients resistant to conventional therapy.
MEXILETINE (Mexitil/Boehringer)
Therapy for symptomatic ventricular arrhythmias. FDA Advisory Committee approval.
Treatment of symptomatic sustained ventricular tachycardia.

Coronary Vasodilators

NITRO-DUR (Key)
TRANSDERM—NITRO (Ciba)
NITRODISC (Schering)

Inotropic (Strengthen heart muscle)

MILRINONE (Sterling)
Potent oral analogue of amrinone. Has combined inotropic and vasodilatory properties. Appears to be remarkably free of adverse effects.
IV AMRINONE (Inocor/Winthrop-Breon)
Approved by FDA in August, 1984. First in a new class of bipyridine derivatives with potent inotropic activity and vasodialtor properties.

HORMONES/DIABETICS/BIOLOGICS

Second Generation Oral Hypoglycemics

GLYBURIDE (Micronase/Upjohn)
Original name was glibenclomide.
GLIPIZIDE (Glucotrol/Pfizer)
Second generation hypoglycemics are similar to first generation agents. However, they differ kinetically, are long-acting and require only once or twice daily dosing.
SORBINIL (Pfizer)
TORESTAT (Ayerst)
HUMAN INSULIN
NASAL SPRAY INSULIN

ANALGESICS

HYDROMORPHINE HIGH POTENCY (Dilaudid-HP/Knoll)
A more potent injectable form approved in early 1984. Indicated for moderate to severe pain in narcotic tolerant patients.
SUFENTANIL (Sufenta/Janssen)
Parenteral highly potent opiate analgesic-anesthetic. An analogue of fentanyl.
ALFENTANIL
LOFENTANIL
CARFENTANIL

MUSCLE RELAXANTS

ATRACURIUM (Tracrium/Burroughs Wellcome)
VECERONIUM (Norcuron/Organon)

ANTIINFLAMMATORIES/PROSTAGLANDINS

New Enzyme Discoveries

Nonsteroidal Antiinflammatories

ISOXICAM (Maxicam/Warner)
An oxicam about 1/10 as potent as piroxicam. A potent inhibitor of platelet aggregation and potentiates action of warfarin.
OXAPROZIN (Oxapro/Wyeth)
ETODOLAC (Ultradol/Ayerst)
FENBUFEN (Clinopal/Lederle)
Not active as parent compound. Major metobolite, biphenylacetic acid, inhibits prostaglandin synthetase. Twice daily dosage.
SUPROFEN (Suprol/Ortho)

Antiarthritics

SLOW RELEASE ASPIRIN (Zovprin/Boots)
AURANOFIN (Ridaura/SKF)
29% elemental gold complexed with triethylphosphine. Effective orally, well absorbed with diarrhea the most frequent adverse effect.

COUGH/COLD, RESPIRATORY AGENTS

Single dose theophylline

KETOTIFEN (Zedatin/Sandoz)
Appears to be a potential alternative in the prophylaxis of asthma. Several weeks of administration are required to produce maximum prophylactic effects. Frequently produces marked drowsiness. Available in Europe.
IPRATROPIUM (Atrovent/Boehringer Ingelheim)
Available in England and appears effective in COPD and in asthma. Protects against cholinergic, allergen and histamine challenge. Variable protection is provided against exercise-induced bronchospasm.

GASTROINTESTINAL

Histamine 2 Receptor Blockers (H2)

RANITIDINE (Zantac/Glaxo, Roche)
FAMOTIDINE (MSD)
PIRENZEPINE (Gastrozepine/Boehringer Ingelheim)
A tricyclic benzodizepine anti-ulcer agent. To compete with H2 receptor blockers but with a unique selective antimuscarinic activity for gastric acid secretory cells. Clinical studies indicated effectiveness equivelant to cimetidine in the treatment of peptic ulcer disease.
OMEPRAZOLE
Appears to be a potent, long acting antisecretory drug in patients with Zolinger-Ellison syndrome. Possibly effective in patients whose peptic-ulcer disease is relatively resistant to treatment with H2 receptor antagonists.

Continued Page 8

UPDATE continued

Antiemetics

DOMPERIDONE (Jansen)
May be an effective alternate to available antiemetics. Produces variable effects on cytotoxic chemotherapy-induced nausea and vomiting.

ANTICANCER

VINDESINE (Eldisine/Lilly)
An synthetic investigational drug derived from vinblastine, but more closely resembles the activity of vincristine. A large number of studies support its utility in a diverse group of cancer types. Major and dose-limiting toxicities include myelosuppression and neurotoxicity.

ETOPOSIDE (VP16-213; VP16; VePesid)
Indicated for refractory testicular tumors. It was rated "A" by FDA as a new molecular entity that provides an important therapeutic gain.

TENIPOSIDE (VM26; Vumon)
Semisynthetic derivative of podophyllin from American mandrake. Shows promise in Hodgkin's disease and other malignant lymphomas.

MISCELLANEOUS AGENTS

BENTIROMIDE (Chymes/Adria)
Noninvasive diagnostic agent for pancreatic exocrine insufficiency and to monitor therapy with pancreatic supplements.

NICOTINE RESIN COMPLEX (Nicorette/Merrel-Dow)
Chewing gum utilitzed as a smoking deterrent.

NEW INDICATIONS

METOPROLOL (Lopressor/Ciba-Geigy)
Approved for early intervention in acute myocardial infarction.

ACETAZOLAMIDE (generic/various)
Approved for the prevention and treatment of symptoms of acute mountain sickness.

CIMETIDINE (Tagament/SKF)
Approved for symptomatic relief of gastroesophogeal reflux disease, for twice daily dosing in duodenal ulcer therapy and for management of stress ulcer.

CEFTIZOXIME (Cefizox/SKF)
Approved for use in children over 6 months of age and for treatment of meningitis caused by H. influenzae.

CHOLESTYRAMINE (Questran/Mead-Johnson)
New indication to reduce risks of atherosclerotic coronary disease and myocardial infarction.

CALCITONIN (Calcimar/USV)
Approved for treatment of osteoporosis in postmenopausal women.

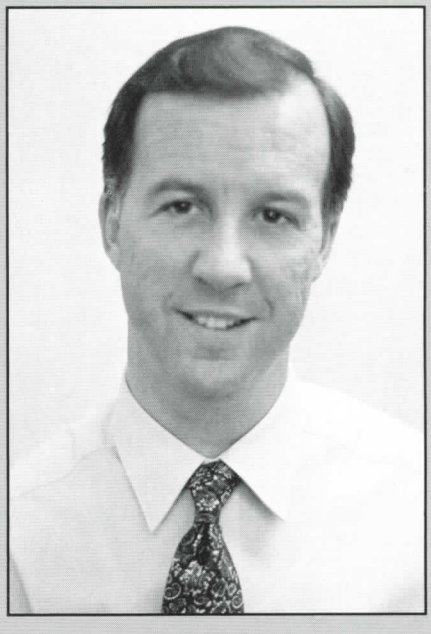
DESMOPRESSIN (Stimate/Armour)
Approved for management of hemphilia R, von Willbrand's disease (type 1) and diabetes insipidus.

RHEUMATOLOGIST IS CERTIFIED

The American Board of Internal Medicine has notified Dr. Jeffery L. Matthews that he successfully completed his examinations and is now certified in the medical subspecialty of rheumatology. Dr. Matthews is also certified as an internal medicine specialist.

Dr. Matthews was born and raised in Salt Lake City and graduated from the University of Utah. He completed an internship and a two-year residency in internal medicine at Duke University and a fellowship in rheumatology at the University of Utah.

Dr. Matthews is a member of the Utah Valley Regional Medical Center medical staff and maintains a private practice at 269 East 400 South in Springville.



Jeffrey L. Matthews, M.D.

Vicki McClellan and Mary Ann Young

YOUNG AND McCLLELAN TO LEAD NURSING

The UVRMC Administration has appointed Mary Ann Young, R.N. new assistant administrator of Nursing and Vicki McClellan, R.N. as associate director. Mary Ann replaces Maurine Lowery, R.N., who will retire this June after 33 years of service to the hospital.

"The biggest nursing challenge in the new few years will be to provide high quality patient care and consumer satisfaction, given the constraints imposed upon us by government regulations, insurance reimbursement, and high health care costs," says Mary Ann.

As an appointed member of the Utah State Board of Nursing, Mary Ann helps develop policies governing nursing practice in Utah. For the past eight years, she has been assistant director of Nursing over the adult critical care units at UVRMC. She has a bachelor's degree in Nursing and a master's degree in Public Administration/Health Services from Brigham Young University, where she is now a faculty member.

Vicki McClellan will assist Mary Ann in her administrative responsibilities in the newly-created associate directorship. "One of my major goals will be to build more flexibility into the nursing organization at Utah Valley so that we can adapt to the continuing changes in the health care market," she says.

Vicki was previously assistant director of Nursing in the UVRMC Perinatal Center for seven years. She also received her B.S. degree in Nursing from BYU and will complete an M.S. degree in Nursing Administration at the University of Utah this fall.

"Nurses make a great contribution to health care," concludes Mrs. Lowery. "This new leadership will promote the continued growth of professional nursing and maintain a commitment of quality nursing care to the community."

BLEH HEADS NEW MEDICAL SOCIAL WORK DEPARTMENT

UVRMC has formed a Medical Social Work department and appointed Charlotte Bleh, M.S.W. the new director.

Charlotte was previously manager of the Family Resouce Center at Orem Community Hospital. She received a master's degree in Social Work from the University of Utah and has worked as a vocational counselor, an alcohol counselor at the Utah State Penitentiary, and a youth counselor and program evaluator for the Division of Youth Corrections.

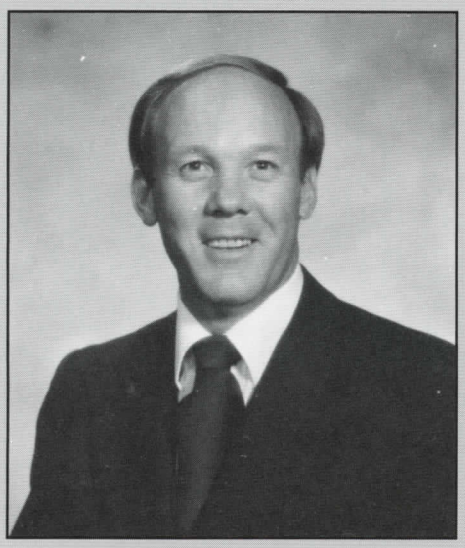
Charlotte says she became interested in medical social work after the unexpected illness and death of her first husband left her with five children, one just newborn. "The personal difficulties I faced then gave me a basis for understanding the issues, concerns, and emotions of patients at Utah Valley."

The function of Medical Social Work, according to Charlotte, is to care for the patients needs outside their medical treatment. "When a person is admitted to the hospital, the whole family is admitted, in a sense. Our philosophy is that a patient can't recover well if their family, financial, and job worries aren't taken care of.

"We help take care of immediate problems and then refer to other resources in the community, taking care to follow-up on those referrals."

Charlotte Bleh, M.S.W.

HOSPITAL CONSOLIDATION EXPECTED TO PRODUCE SAVINGS



Merril Gappmayer Chairman

Orem Community Hospital and Utah Valley Regional Medical Center have been consolidated under a single board and a combined administrative staff announced David H. Jeppson, President of IHC Hospitals, Inc. IHC Hospitals, Inc., is a subsidary of Intermountain Health Care, Inc. "The first step in the consolidation was the organization of a single, consolidated community hospital board," says Jeppson. "Members of the new consolidated board represent the diverse interests of the communities served by both hospitals," he says.

One of the consolidated boards first responsibilities, Jeppson notes, will be to finalize plans for the expansion of both services and facilities at Orem Community Hospital.

An Administrative restructuring has also taken place. Mark Howard, Administrator of UVRMC, is the new Executive Director of the consolidated organization. Larry Carter, Administrator at Orem Community Hospital will remain in this position. Keith Tintle, Associate Administrator at UVRMC, is the new administrator at UVRMC.

In addition, a task force made up of physicians and administrative personnel from both hospitals has been organized to consider the most appropriate form of medical staff organization.

The main purpose of the consolidation, says Jeppson, is to maximize cost-effective patient care and to permit both hospitals to combine common services. "Ther is little to be gained by two or our facitlites only 4 miles apart not working closely together," he says. "The new consolidation will benefit from Central Board direction, the new administrative structure and sharing common services," he says.

"The consolidation further demonstrates IHC's commitment to continue to provide quality patient care at the most reasonable cost," Jeppson notes.

Specifics of the new consolidation will be announced by the hospital as decisions are made concerning the new board, medical staff orgainiztion and related issues.

The new administration offered reassurance to employees that operations will continue at both hospitals and that there will be no immediate impact on employment. "Job security for all employees is of utmost concern," said the new Chief Executive Officer, Mark Howard, "and we will have their interests foremost in mind as the consolidation takes place."

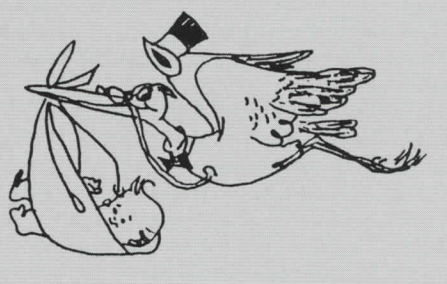
STORKLINE LETS DAD KNOW BABY'S COMING

With coach-supported labor and delivery so popular nowadays, expectant fathers are an integral part of the birthing experience. To help make sure fathers are present at the birth of their children, UVRMC is beginning "Storkline," a rental pager service.

Storkline enables an expectant mother to notify her husband when she goes into labor, no matter where he may be. "The idea was suggested by patients," says Chris Coons, marketing director. "Schooling, sales work, and many other jobs keep men out and away from phones. This just provides extra security for the wife, knowing that her husband will be there when she needs him."

Here's how the Storkline rental program works. Expectant parents come to the hospital at least two weeks before the baby's due date to complete admitting papers and verify their insurance coverage or payment plan. At that time, they can also make a deposit on the pager unit and rent for just five dollars a week.

The initial deposit for Storkline goes toward the hospital bill when the pager is returned at the time of delivery, or is refunded according to insurance coverage.



MARIJUANA 10 TIMES MORE TOXIC THAN TOBACCO

The American Lung Association of Utah today launched an education campaign aimed at dissuading children from using marijuana, according to R. James Steenblik, President, Bountiful.

The goal of the project, called "Marijuana: A Second Look", is to show 9 to 12 year-olds and their parents new evidence of the damage marijuana smoke causes the lungs. First Lady Nancy Reagan is honorary chairman of the nationwide campaign.

"Marijuana is about 10 times more potent now than it was a decade ago," said Mr. Steenblik, "and is more toxic and irritating to the lungs than cigarettes." Research indicated that in young people who regularly used strong marijuana, precancerous tissue changes occur in the airways that are equivalent to 10 to 20 years of heavy cigarette smoking.

The consequences of smoking marijuana to developing lungs are so serious the Lung Association decided to undertake a prevention campaign geared toward pre-teens, Steenblik added. The educational program is limited to the pulmonary considerations of marijuana use.

"To have a correct understanding of the consequences of smoking marijuana is the basis for correct decision-making about its use," Steenblik explained.

According to American Lung Association statistics, 1.7 million Americans will smoke marijuana for the first time this year and 80 percent of them will be 17 or younger. The association says virtually every American child between 12 and 14 is now faced with the decision of whether to try marijuana. Twenty million people use the drug regularly.

Marijauna: A Second Look will be a three-part state-wide education program. 1. A public awareness campaign. 2. A school and youth group program. 3. A parent and youth leader program.

Educational materials for children and parents and classroom activities for teachers and community youth leaders are now available from the American Lung Association of Utah. They may be obtained by sending a request to 1930 South 1100 East, Salt Lake City, Utah 84106 or calling 484-4456.

The educational materials to launch the program in Utah were provided through a generous and timely grant from Northwest Pipeline Corporation of Salt Lake City, one of the Willaims companies.

Why focus on elementary school children when marijuana smoking is more widespread among teenagers? "The children need to know where they stand on drug use before they are challenged to make a decision," said Steenblik. "Youngsters in the upper elementary grades still care deeply about what parents and teachers think. As they reach the teens, they are more influenced by their peers. Our purpose is to prepare them to say no to future invitations to smoke marijuana.

OFFICE STAFF GO THE EXTRA MILE

By Pat Anderson, Utah Neurological Clinic

The office staff in a doctors office is the liaison between the doctors and their patients. Often, the reality is, that even though our salaries are paid by the doctor, our major service is to the patient.

Every telephone call, even by the tone of voice, a message of concern is, or should be, conveyed to the patient. An interested, helpful response is a consolation to a relative or a patient who is distressed. Taking the time to hear the problem through is sometimes the release needed for the tension that the person is experiencing.

We explain how to go about getting help when it is more urgent than we are able to accomodate with an office appointment, such as getting a referral from their primary or family physician, or going to the emergency room.

Assisting people with their insurance problems, helping older people with their insurance forms, asking for a review for increased payments, and working with the insurance companies in behalf of the patient is a big part of our responsibility.

Filling out disability forms for banks, mortgage holders on house, trucks, etc. for industrial accident patients so that they will receive their compensation payments and their other financial responsibilities are covered.

Even tending children while the parent is being tested or examined is not unusual duty.

Once in a while there arises a situation in which a possible life or death is involved. Fortunately, these situations are not routine in the office, but how one rises to the challenge is a test.

Recently one of our employees made a call to a patient to ascertain his address in order to mail the admitting forms for the hospital. She has spoken to him only about five minutes before and he seemed to be fine. On the second call, to verify a detail, he did not answer. Thinking this odd because she had just spoken to him, she let the phone ring several times. The patient answered with a very weak voice. He was breathing heavily and was in distress. She asked if he was okay. He answered, "No." She asked if he needed an ambulance, and he answered, "Yes." There was some delay in getting his precise address, but simultaneously another employee got on the telephone and called the "0" operator and inquired about how to get an ambulance to a town in the southern part of the state. By the time the address was obtained, the operator had an ambulance ready to go.

The patient arrived at the hospital and emergency surgery was performed the next morning.

A general feeling of satisfaction was experienced by all staff at the Clinic.

WILL DOCTORS TURN PATIENTS AWAY AT THE DOOR?

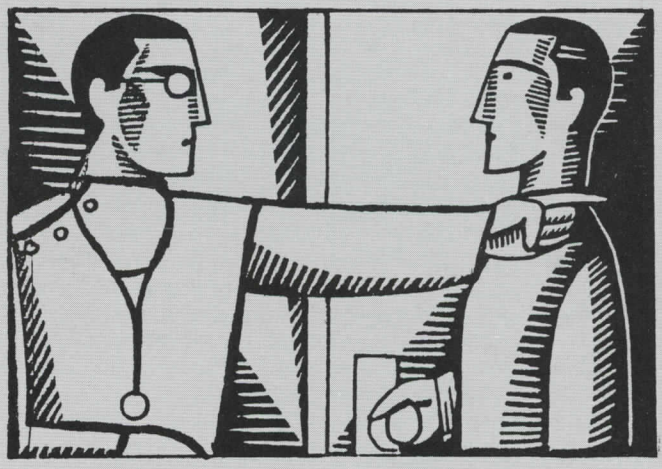
NEWS AND TRENDS INC. MAG - APRIL 1985

Preventive medicine has taken on a new meaning—to protect the doctor from malpractice suits. Paul Huth, a lawyer in Detroit, founded Physician's Alert in 1983 to help doctors avoid malpractice claims by identifying litigious patients in advance. The information will help doctors decide how—and even *whether*—to treat people who ask for their help.

Before starting the business, Huth found in his own survey that 35% of all the people who filed malpractice suits in Detroit during a three-month period had been plaintiffs in previous civil actions. When he started Physician's Alert, he sent workers to check the docket in the city courthouse manually; now, Docket Search Network Inc., in Chicago, which acquired Physician's Alert last fall, is completing a computerized file of every civil action in Detroit since 1948.

Ten years of Chicago records have already been computerized. To check a patient's litigation history, Chicago doctors call DSN's office, where a clerk performs a search and reads the results within 15 seconds. DSN charges doctors an annual fee of $150, plus an additional charge for each request.

Huth figures he can sign up at least 5% of the doctors in any city because of increasing concern about lawsuits. Patients are filing three times as many malpractice suits as they did a decade ago, according to the American Medical Association, and malpractice insurance can now cost a doctor more than $60,000 a year.



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